

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44337

STATE FILE NUMBER

FILED JAN 7 1957

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2919

Health, Welfare and Public Service
300
156
All diseases in Part I must be casually related. Carcener cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with- or without.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY, <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hillsdale</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hillsdale</u> <u>43010</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1830 Lucas Hunt Rd.</u> Length of stay in 1b <u>84 years</u>		d. STREET (If outside, give location) ADDRESS <u>1830 Lucas Hunt Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MR. LOUIS WILLIAM STREICHER</u> First Middle Last			4. DATE OF DEATH <u>Dec. 10, 1956</u> Month Day Year
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1872</u>
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Farming</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Leo Streicher</u>	
14. MOTHER'S MAIDEN NAME / wife's name: <u>Barbara Hamon / Martha Stricher</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yrs. give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mildred Falor 1830 Lucas Hunt Rd.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Cardio-vascular disease</u> DUE TO (c) <u>4221</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE	
21. I attended the deceased from <u>Feb. 1950</u> to <u>12/10/56</u> and last saw her alive on <u>12/9/56</u> Death occurred at <u>3:00 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Leanne S. Mellie MD</u> (Degree or title)		22b. ADDRESS <u>7518 Forest View Dr</u>	
22c. DATE SIGNED <u>12/10/56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 12, 1956</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		23d. LOCATION (City, town, or county) (Specify) <u>St. Louis County 20, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Alexander & Sons, Inc. 6175 Delmar Blvd.</u>		25. DATE REC'D. BY LOCAL REG. <u>12-11-56</u>	
26. REGISTRAR'S SIGNATURE <u>Herbert B. Donley MD</u>			

Dr. Eugene Mellies
7518 Forestview Dr.
Ev. 3 5546

*F. ...
Rt. ... Forestview*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *27*

P. O. Address *61502*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.